TEMPUS UNLIMITED, INC.
Opportunities for Independence
*formerly Cerebral Palsy of Massachusetts, Inc.*

Date

Consumer Name
Address
City, State, Zip Code

**TO:** Consumers Transferring from Stavros FI or Northeast Arc FI
**FROM:** Fiscal Intermediary Department

**RE:** FI Transfer Packages

Welcome to the Tempus Unlimited, Inc. Fiscal Intermediary (FI) program. You are receiving this packet based upon information provided by your current FI that you are receiving PCA Services. In order to transition from your current FI to Tempus, two forms need to be completed. They are required to ensure a smooth transition and timely payroll processing. The following is a list of the forms and a brief description of their purpose:

**2678 Employer Appointment of Agent:** This form will allow Tempus Unlimited, Inc. to file the appropriate forms with the Internal Revenue Service (IRS) as an agent of the Consumer. If possible, the Consumer should complete and sign this form. If the Consumer is unable to sign, a Power of Attorney or Legal Guardian may do so. In that case, the documents granting those powers must also be provided. If the consumer signs with an X, mark or stamp the signature need to be witnessed by someone other than the PCA.

SAMPLE

**Consent to the Use and Disclosure of Protected Health Information:** By completing and signing this form, the Consumer acknowledges consent/non-consent regarding the release of PHI and permission to leave detailed voicemails on their home/cell phone.

**Tempus Unlimited, Inc. Notice of Privacy Practices (NPP):** The NPP describes how your Protected Health Information (PHI) may be used or disclosed, and how you may access this information. This form is informational only and does not need to be signed or returned.

Please return completed forms via:

- Fax: 1-800-359-2884
- Mail: 600 Technology Center Drive, Stoughton, MA 02072

Please complete and return these forms no later than October 8, 2021.

If you have any questions, please contact Tempus Unlimited, Inc. at Toll-Free at 1-877-479-7577 Monday through Friday between the hours of 7:30AM and 4:30PM. One of our Consumer Relations Specialists will be happy to assist you.

Date

**PARA:** Consumidores transfiriendo desde el FI de Stavros o del FI de Northeast Arc
**DE:** El Departamento de Intermediario Fiscal

**ASUNTO:** Paquetes de transferido del Intermediario Fiscal (FI)

Bienvenido al programa Intermediario Fiscal (FI por sus siglas en inglés) de Tempus Unlimited, Inc. Usted está recibiendo este paquete basado en la información provista por su FI actual que indica que usted está recibiendo servicios de atendiente del cuidado personal (PCA por sus siglas en inglés). Para realizar la transición de su FI actual a Tempus, es necesario completar dos formularios. Son necesarios para garantizar una transición sin problemas y el procesamiento a tiempo de la nómina. La siguiente es una lista de los formularios y una breve descripción de su propósito:

**<u>2678 Designación de agente por parte del empleador:</u>** Este formulario le permitirá a Tempus Unlimited, Inc. presentar los formularios correspondientes al Servicio de Impuestos Internos (IRS por sus siglas en inglés) como agente del consumidor. Si es posible, el consumidor debe completar y firmar este formulario. Si el consumidor no puede firmar, un poder notarial o tutor legal puede hacerlo. En tal caso, también deberán aportarse los documentos que otorguen dichas facultades.Si el consumidor firma con una X, marque o selle la firma necesaria para que sea testigo de otra persona que no sea el PCA.

SAMPLE

**<u>Consentimiento para el uso y divulgación de información médica protegida:</u>** Al completar y firmar este formulario, el Consumidor reconoce el consentimiento / no consentimiento con respecto a la divulgación de información médica protegida (PHI por sus siglas en inglés) y el permiso para dejar mensajes de voz detallados en su teléfono celular o de casa.

**<u>Tempus Unlimited, Inc aviso de prácticas de privacidad (NPP por sus siglas en inglés):</u>** El NPP describe cómo se puede usar o divulgar su información médica protegida (PHI) y cómo puede acceder a esta información. Este formulario es solo informativo y no necesita ser firmado ni devuelto por usted.

Por favor envíe los formularios completados a través de:

- Fax: 1-800-359-2884
- Correo: 600 Technology Center Drive, Stoughton, MA 02072

Favor de completar y devolver estos formularios no más tardar del 8 de Octubre, 2021.

Si tiene alguna pregunta, comuníquese con Tempus Unlimited, Inc. al número gratuito 1-877-479-7577 de lunes a viernes entre las 7:30 a.m. y las 4:30 p.m. Uno de nuestros especialistas en relaciones con el consumidor estará encantado de ayudarle.

La versión en español de este documento se puede encontrar en nuestra página de web tempusunlimited.org.

Form **2678** **Employer/Payer Appointment of Agent**

(Rev. August 2014) Department of the Treasury — Internal Revenue Service

FI:
FI Consumer No:
Consumer:

OMB No. 1545-0748

**For IRS use:**

**Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.**

- If you are an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

  **Note.** This appointment is not effective until we approve your request. See the instructions for filing Form 2678 on page 3.

- If you are an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

## Part 1: Why you are filing this form...

(Check one)

☑ You want to **appoint** an agent for tax reporting, depositing, and paying.

☐ You want to **revoke** an existing appointment.

## Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.

**1 Employer identification number (EIN)** 0 1 – 2 3 4 5 6 7 8

**2 Employer's or payer's name** (not your trade name): Consumer Name

**3 Trade name** (if any):

**4 Address**

Address
Number Street Suite or room number

City (City) State (State) Zip Code (ZIP code)

Foreign country name Foreign province/county Foreign postal code

SAMPLE

**5 Forms for which you want to appoint an agent or revoke the agent's appointment to file.** *(Check all that apply.)*

| | For ALL employees/ payees/payments | For SOME employees/ payees/payments |
|---|---|---|
| Form 940, 940-PR (Employer's Annual Federal Unemployment (FUTA) Tax Return)* | ☑ | ☐ |
| Form 941, 941-PR, 941-SS (Employer's QUARTERLY Federal Tax Return) | ☑ | ☐ |
| Form 943, 943-PR (Employer's Annual Federal Tax Return for Agricultural Employees) | ☐ | ☐ |
| Form 944, 944(SP) (Employer's ANNUAL Federal Tax Return) | ☐ | ☐ |
| Form 945 (Annual Return of Withheld Federal Income Tax) | ☐ | ☐ |
| Form CT-1 (Employer's Annual Railroad Retirement Tax Return) | ☐ | ☐ |
| Form CT-2 (Employee Representative's Quarterly Railroad Tax Return) | ☐ | ☐ |

*Generally you cannot appoint an agent to report, deposit, and pay tax reported on Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return, unless you are a home care service recipient.

☑ Check here if you are a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

**Sign your name here**

Print your name here: Consumer Name

Print your title here: HCSR

Date: / /

Best daytime phone:

**Now give this form to the agent to complete.** ➡



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**Part 3:** **Agent Information: If you will be an agent for an employer or payer, or want to revoke an appointment, complete this part.**

**6 Agent's employer identification number (EIN)** 04 – 3770718

**7 Agent's name** (not trade name) Tempus Unlimited, Inc.

**8 Trade name** (if any)

**9 Address**

600 Technology Center Drive

Number Street Suite or room number

Stoughton | MA | 02072

City State ZIP code

Foreign country name Foreign province/county Foreign postal code

☑ Check here if the employer is a home care service recipient receiving home care services through a program administered by a federal, state, or local government agency.

Under penalties of perjury, I declare that I have examined this form and any attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

**Sign your name here**

Print your name here

Print your title here Intake Coordinator

Date / /

Best daytime phone 1-877-479-7577

SAMPLE

FI:
FI Consumer No:
Consumer:

# Consent to the Use and Disclosure of Protected Health Information

I hereby give my consent for Tempus Unlimited, Inc. to use and disclose protected health information (PHI) on my behalf to enable billing and reimbursement for services provided by the Tempus Unlimited Fiscal Intermediary program. I understand that Tempus Unlimited, Inc. staff may have access to the following types of PHI and may use this information to either approve or deny timesheets and/or to submit billing for reimbursement or for other program billing and reimbursement. Types of PHI that we may share could be a MassHealth ID, other payer Insurance IDs, admit and discharge paperwork for inpatient stays, and information of your stay at a long term care facility. We only use this information to provide documentation to MassHealth and other payers for reimbursement for FI services. We also use this information to ensure that timesheets are not submitted fraudulently and that we are billing MassHealth for actual work done by PCA or worker that you have authorized. We also use this information for staff training and for conducting quality assurance, (monitoring the need, appropriateness, and quality of services provided).

I have been given a Notice of Privacy Practices that fully explains the uses and disclosures that Tempus Unlimited, Inc. will make with my protected health information (PHI). I understand and have been given the right to review the *Notice of Privacy Practices* before signing this consent. Tempus Unlimited, Inc. has given sufficient time for me to review the *Notice of Privacy Practices* and has answered any questions I may have had to my satisfaction.

I understand that I do not have to consent to the use or disclosure of my protected health information for payment, and health care operations, but that if I do not consent, Tempus Unlimited, Inc. may refuse to provide me Fiscal Intermediary services unless applicable state or federal law requires Tempus Unlimited, Inc. to provide such services. If Tempus Unlimited, Inc. does agree to my requested restrictions, it is bound by this agreement.

SAMPLE

The following person(s) have my consent regarding my protected health information. **You have my permission** to release information to them or **I am adding the access** of the following persons:

Name________________________________Relationship________________________

Name________________________________Relationship________________________

I understand that I have the right to object to the use and/or disclosure of my protected health information to family members. **You do not have my permission** to release information to them or **I am revoking the access** of the following persons:

Name________________________________Relationship________________________

Name________________________________Relationship________________________

**Password:** I would like to have a password added to my account. Information will not be disclosed over the phone unless the following password is used:

Password______________________________________Effective Date: ____________________

**Permission to leave detailed voicemails on my home or cell phone voicemail:**

◯ Yes, you have my permission ◯ No, you do not have my permission

I understand that I may revoke this consent in writing but that the revocation will not be effective to the extent that Tempus Unlimited, Inc. has already taken action based on my earlier consent. **This consent will be in effect, if not revoked, until one month after the termination date of your Program**.

______________________________ ______________________ ____________

**Signature of Consumer/Surrogate** **Printed Name** **Date**
**Legal or Personal Representative**

TEMPUS UNLIMITED, INC.
Opportunities for Independence
formerly Cerebral Palsy of Massachusetts, Inc.

FI:
FI Consumer No:
Consumer:

**Consentimiento para el Uso y la Divulgación de Información Protegida de Salud**

Por este medio le doy mi consentimiento a Tempus Unlimited, Inc. para utilizar y divulgar información protegida de salud (PHI) sobre mí para llevar a cabo tratamiento, pago y operaciones de atención médica (TPO). Entiendo que Tempus Unlimited, Inc. y sus profesionales del cuidado de salud y empleados pueden utilizar esta información para planificar mi cuidado, comunicarse con otros profesionales del cuidado de salud con respecto a mi caso, documentar servicios para pago/reembolso y gestionar operaciones del cuidado de salud rutinarias tales como el aseguramiento de calidad (monitorear la necesidad, aptitud y calidad de los servicios provistos) y el entrenamiento del personal.

Me han dado un Aviso de Prácticas de Privacidad que explica plenamente los usos y las divulgaciones que Tempus Unlimited, Inc. hará con mi información de salud. Entiendo y se me ha dado el derecho de revisar el *Aviso de Prácticas de Privacidad* antes de firmar este consentimiento. Tempus Unlimited, Inc. ha dado suficiente tiempo para yo poder revisar el *Aviso de Prácticas de Privacidad* y ha contestado cualquier pregunta la cual pude haber tenido a mi satisfacción.

Entiendo que no tengo que dar el consentimiento al uso o divulgación de mi información de salud para tratamiento, pago y operaciones de atención médica, pero si no consiento, Tempus Unlimited, Inc. tiene el derecho de denegar proveerme servicios de cuidado de salud a menos que la ley aplicable del estado o federal le requiera a Tempus Unlimited, Inc. facilitar esos servicios. Si Tempus Unlimited, Inc. está de acuerdo con mis restricciones pedidas, es obligado por el presente acuerdo.

La(s) siguiente(s) persona(s) tiene(n) mi consentimiento con respecto a mi información de salud. **Usted tiene mi permiso** para divulgarles información o **le estoy añadiendo acceso** a la(s) siguiente(s) persona(s):

Nombre________________________________Relación___________________

Nombre________________________________Relación___________________

Entiendo que tengo el derecho a objetar al uso y/o divulgación de mi información de salud a familiares. **Usted no tiene mi permiso** para divulgarles información a ellos o **le estoy revocando el acceso** de las siguientes personas:

Nombre________________________________Relación___________________

Nombre________________________________Relación___________________

**Contraseña:** Me gustaría añadirle una contraseña a mi cuenta. Información no será discutida por teléfono amenos que la siguiente contraseña sea usada:

Contraseña:____________________________________Fecha de vigencia: ___________________

**Permiso para dejar mensajes de voz detallados en mi grabadora de mensajes en mi hogar o teléfono celular:**

◯ Si, usted tiene mi permiso ◯ No, usted no tiene mi permiso

Entiendo que puedo revocar este consentimiento por escrito pero que la revocación no estará en efecto hasta el punto que Tempus Unlimited, Inc. ya haya tomado acción basada en mi consentimiento anterior. **Este consentimiento estará en efecto, de no ser revocado, hasta un mes luego de la fecha de terminación de su programa.**

______________________________ ______________________ ____________

**Firma del Consumidor/Delegado Representante Legal o Personal** | **Nombre impreso** | **Fecha**

SAMPLE

Notice of Privacy Practices August, 2021

This notice describes how Protected Health Information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

This notice is provided on behalf of Tempus Unlimited, Inc. herein named the Agency.

**PURPOSE**: This notice of Privacy Practices describes how we may use and disclose your Protected Health Information to carry out payment for Fiscal Intermediary program services, required by the contract entered into between the Massachusetts Executive Office of Health and Human Services and Tempus Unlimited, Inc. Protected Health Information is information that may identify the Consumer and that relates to the consumer's past, present or future physical or mental health, and may include name, address, phone numbers and other identifying information.

We are required by law to give you this notice and to maintain the privacy and security of your protected health information.

We must abide by this Notice, but we reserve the right to change the privacy practices described in it. A current version of this Notice, may be obtained from the Agency website, www.tempusunlimited.org, and will be posted in our offices. You may also request a current copy by sending a written request to the Agency Compliance Department, 600 Technology Center Drive, Stoughton, MA 02072

We understand that medical information about you and your health is personal and confidential, and we are committed to protecting the confidentiality of your Protected Health Information. We create a record of the care and services you receive at the Agency. We need this record to provide services to you and to comply with certain legal requirements. This Notice will tell you about the ways we may use and disclose your information. We also describe your rights and certain obligations we have to use and disclose your protected health information.

SAMPLE

If you believe your Privacy Rights have been violated, you may make a complaint to us or to the US Secretary of Health and Human Services at: http://www.hhs.gov/. To file a complaint with us, you may send a letter describing the violation to Tempus Unlimited, Inc. Compliance Department, 600 Technology Center Drive, Stoughton, MA 02072. You also may email a complaint to Grievance@TempusUnlimited.org.

There will be no retaliation for filing a complaint.

WHO WILL FOLLOW THIS NOTICE: This notice describes the practices of Agency health care professionals, employees, volunteers and others who work in any of the Tempus Unlimited, Inc. Programs that you may participate in.

**Your Privacy Rights:**

You have the following rights relating to your Protected Health Information and may:

- Obtain a current paper copy of this Notice.
- Inspect or obtain a copy of Agency created documents. Your request to obtain a copy of these documents must be in writing or in a format that allows us to verify the requestor as the Consumer or Guardian or other designated individual.
- Request that we amend your Protected Health Information (PHI), if you feel the information is incomplete or incorrect.
- Obtain a record of certain disclosures of Protected Health Information.
- We will obtain your written permission for uses and disclosures of your Protected Health information sent to you by alternative means or at alternative locations.
- We will obtain your permission for uses and disclosures of your Protected Health Information that are not covered by the Notice or permitted by law. Except to the extent that the use or disclosure has already occurred, you may cancel this permission. This request to cancel must be put in writing or in a format that allows us to verify the requestor as the Consumer or Guardian or other designated individual.

**Our Responsibilities:**

We are required by law, to maintain the privacy and security of your protected health information and to abide by the terms of this Notice. We will let you know promptly if an incident occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can. If you tell us we can, you may change your mind at any time. We will request that you submit that request in writing. We will offer an accommodation to document your request if needed.

**Examples of Uses and Disclosures**

We will use your Protected Health information to provide services.

- Public Health: We may give your Protected Health Information to public health agencies who are charged with preventing or controlling disease, injury or disability and is required by law.
- Communicable Disease: We may disclose your Protected Health information to a person who may have been exposed to a communicable disease or may be otherwise at risk of contracting or spreading the disease or condition, if authorized by law to do so, such as a disease requiring isolation.
- Law Enforcement: We must disclose your Protected Health Information for law enforcement purposes as required by law.
- As Required by Law: We must disclose your protected health Information when required by federal, state or local law.
- Health Oversight: We must disclose your Protected Health Information to a health oversight agency for activities authorized by law, such as investigations and inspections. Oversight Agencies are those that oversee the healthcare system, government benefit programs, such as Medicaid, and other government regulatory programs.
- Abuse or Neglect: we must disclose your Protected Health Information to government authorities that are authorized by law to receive reports of suspected abuse or neglect.
- Legal Proceedings: We may disclose your protected Health information in the course of any judicial or administrative proceeding or in response to a court order, subpoena, discovery request or other lawful process.
- Required Uses and Disclosures: We must make disclosures when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the HIPAA Privacy Regulations.
- To Avoid Harm: We may use and disclose information about you when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.
- For Specific Government Functions: In certain situations, we may disclose Protected Health Information of veterans. We may disclose your Protected Health Information for national security activities required by law.

SAMPLE

**This information is important. It should be translated right away.**

Esta información es importante y debe ser traducida inmediatamente. (Spanish)

Esta informação é importante. Deverá ser traduzida imediatamente. (Brazilian Portuguese)

此處的資訊十分重要，應立即翻譯。 (Chinese)

Enfòmasyon sa enpòtan. Yo fèt pou tradwi li tou swit. (Haitian Creole)

Những tin tức này thật quan trọng. Tin tức này cần phải thông dịch liền. (Vietnamese)

Эта информация очень важна. Ее нужно перевести немедленно. (Russian)

هذه المعلومات هامة. يجب ترجمتها فوراً. (Arabic)

នេះគឺជាព័ត៌មានសំខាន់។ វាគួរតែបានបកប្រែភ្លាមៗ។ (Cambodian)

Cette information est importante. Prière de la traduire immédiatement. (French)

Questa informazione e importante. Si pregha di tradurla inmediatamente. (Italian)

이 정보는 중요합니다. 이는 즉시 번역해야 합니다. (Korean)

Αυτή η πληροφορία είναι σημαντική και πρέπει να μεταφραστεί άμεσα. (Greek)

To jest ważna informacja. Powinna zostać niezwłocznie przetłumaczona. (Polish)

यह जानकारी महत्वपूर्ण है। इसका अनुवाद भलीभांति किया जाना चाहिए। (Hindi)

આ માહિતી મહત્વની છે. તેનું તરત જ અનુવાદ થવું જોઈએ. (Gujarati)

ຂໍ້ມູນນີ້ເປັນສິ່ງສຳຄັນ. ມັນຄວນຈະໄດ້ຮັບການແປທັນທີ. (Lao)